THE CINCINNATI LIFE INSURANCE COMPANY

Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

Authorization for Release of Information

I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical or medically related facility; the Veterans Administration; MIB, Inc.; any prescription data base service; my employer; and consumer reporting agency or insurance company that has any records or knowledge of the Proposed Insured identified below or his or her health, to furnish such information to The Cincinnati Life Insurance Company, its employees, reinsurer(s), administrative services provider and any other authorized representative upon presenting this authorization.

This authorization includes information about mental illness and the use of drugs, alcohol or tobacco (excluding psychotherapy notes); prescription drug information; sexually transmitted disease; Human Immunodeficiency Virus (HIV) infection; Acquired Immune Deficiency Syndrome (AIDS); and the diagnosis, treatment or prognosis of any physical condition.

I understand that:

1. This authorization may be required in order for my application for insurance to be evaluated and a policy issued;
2. Once this authorization is signed, it will be valid as permitted by applicable law in the state where the policy is issued but not to exceed a time period of 24 months.
3. A photographic copy of this authorization shall be as valid as the original;
4. Any request that I have made to restrict information disclosed does not apply to this authorization. I instruct the providers and entities listed in the first paragraph of this authorization to release and disclose my entire medical record without restriction;
5. The information disclosed under this authorization will be used and may be subsequently disclosed by The Cincinnati Life Insurance Company to: a) underwrite and rate my application for insurance and make eligibility and enrollment determinations; b) obtain reinsurance; c) process other transactions related to my policy; and d) conduct other legally permissible or required activities that relate to any coverage I have or have applied for with The Cincinnati Life Insurance Company;
6. I may obtain a copy of this authorization form by sending a written request to The Cincinnati Life Insurance Company at the above address;
7. I may revoke this authorization at any time by sending a written request to The Cincinnati Life Insurance Company at the above address, but revocation will not affect information that has already been collected and relied upon or disclosed under this authorization; and
8. The information disclosed to The Cincinnati Life Insurance Company pursuant to authorization may be subject to re-disclosure with this authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Cincinnati Life Insurance Company is not protected under the Act. I further authorize The Cincinnati Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB.
9. My treatment, or payment for my treatment, cannot be conditioned on the signing of this authorization. However, if I refuse to sign this authorization The Cincinnati Life Insurance Company may not be able to process my application for insurance, or if coverage has been issued may not be able to make any benefit payments.

Signed on: JAN (Month) 25th (Day) 2019 (Year)

X _____
Name of Proposed Insured
(please print)

Brian McClain
Signature of Proposed Insured
(if signing as personal representative, specify relationship to Proposed Insured)

11-18-1970
Date of Birth (Proposed Insured)

_____
Name of Other Proposed Insured
(please print)

_____
Signature of Other Proposed Insured
(if signing as personal representative, specify relationship to Other Proposed Insured)

_____
Date of Birth (Other Proposed Insured)

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Form CLI-6260-IIPRC (1/17)

Please Complete Two
One for Headquarters – One for Applicant

EXHIBIT
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